House Committee on Veterans Affairs
Statement
Of

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Testimony Before the Subcommittee on Health

Of the House Committee on Veterans Affairs

"Polytrauma Center Care and the TBI Patient: How Seamless is the Transition Between VA and DOD and Are Needs Being Met?

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Good afternoon Mr. Chairman and members of the Committee. My name is Karyn George and I am honored to be here. Before I begin, I need to clearly state that my testimony is based on my personal views and does not represent the views of the Department of Defense or the Administration. I am a contract employee of the Department of Defense and therefore I am a private citizen. I appear before you in that capacity today. My statements and opinions have not been cleared by the Department of Defense or the Federal Government. I do not speak on behalf of the federal government, the Department of Defense, Military OneSource, any of the Military Services, or the Military Severely Injured Center.

Thank-you for the opportunity to present testimony on the care of wounded service members, in particular wounded service members who have sustained brain injuries, as they transition between Department of Defense (DoD) and Department of Veterans Affairs (VA) medical care. I will be testifying today from several perspectives. I am currently employed by Ceridian Corporation as a Service Delivery Manager for Military One Source/Severely Injured Services, a virtual extension of installation services provided by DoD Military Community & Family Policy, 24 hours a day, 7 days a week, at no cost to the Service Member or Family Member. My professional and educational background includes a

Masters Degree in Rehabilitation Counseling, and over 20 years of experience providing case management and administrative oversight of programs designed to treat brain injuries and orthopedic impairments. I also served as a director responsible for a 22 bed in-patient brain injury facility, and as a consultant to start an outpatient brain injury program in Northern Virginia. Thus, I'm bringing you a varied perspective of one who has cared for those with mild to severe brain trauma and other related injuries.

What I have to say today centers around the following four themes:

- My experience with the Military Severely Injured and Military OneSource
- My experience with those who have sustained brain injuries
- Challenges presented along the continuum of care
- My views on the best solutions to care for our wounded and their families

As a Service Delivery Manager, I provide oversight and supervision for the Severely Injured Specialists in the Military OneSource Arlington, Virginia Call Center, and for on-site Counselor Advocates placed at several Military Treatment Facilities (MTFs) and at the VA Medical Center (VAMC) at Palo Alto, CA. The Counselor Advocates (CAs) are charged with providing face to face advocacy, outreach, and support to wounded service members and their families, while the Severely Injured Specialists provide telephonic advocacy, support, short term problem resolution, and long term monitoring of the needs of wounded service members and their families. Prior to assuming this management position, I, myself, was a Counselor Advocate at Walter Reed Army Medical Center.

MOS/SI Services:

In the fall of 2004, then Secretary of Defense Donald Rumsfeld stated: "I think we ought to put together a team to see that the Services take care of their troops after they're wounded, and when they return home and are discharged." Secretary Rumsfeld's statement provided the genesis of what would

become the Military Severely Injured Center (MSIC), which was developed as a specialty service under the Military OneSource contract. Deputy Secretary of Defense Paul Wolfowitz further directed that OSD Personnel & Readiness provide support and augmentation of the Service branch severely injured programs to ensure seamless care as long as it takes. Special emphasis was placed on support of families and on serving as a "safety net". Counselor Advocate qualifications are carefully considered. We (Ceridian) hire masters degree trained individuals in a social service field of study such as vocational rehabilitation, social work, or nursing, experience with case management and disability pathways, and experience and/or exposure to military culture. The first three Counselor Advocates were hired in March 2005 and in April 2005, they were placed at Walter Reed Army Medical Center. The first Military OneSource Severely Injured Specialists were also hired in March 2005 and placed in the Arlington call center. Training was developed collaboratively with DoD Quality of Life personnel. Training included military treatment facility protocols, an overview of existing Service branch injured programs, all military and other government resources such as VA, DoL, DoD, community resources, non-governmental organizations, case management and the continuum of care, and tools/technology needed to be successful in their roles providing services to the wounded and their families.

As the Counselor Advocates assimilated into the treatment facilities, they assisted service members and their families from injury, through recovery and reintegration, back to quality of life. We became familiar with programs, resources, and key personnel at the medical treatment facility or VAMC. We extended ourselves to community and government organizations gleaning knowledge of these resources as well as education on the needs of the wounded service members and their families. I found some needs to be as small as money for groceries, to as large as assisting a family in advocating for assessment of a yet-to-be-diagnosed brain injury of a loved one, to exploration of employment and/or training options for a spouse who had never entered the job market and suddenly found herself the primary breadwinner. A pointed comment from a wounded service member is that the system is a hunt and peck process; if you know what to ask you will probably get the services…but many do not know

what to ask or do not have the "voice" to ask the questions. MOS severely injured staff know not only what to ask, but who and when to ask, to ensure progress along the continuum of care.

The CAs were able to build bridges that today still serve to assist wounded service members and their families. Counselor Advocates have worked side by side, hand in hand with military systems, government organizations, and community programs to meet the needs of the wounded and their families. Another example is assisting in securing resources for additional housing for families of the wounded while at WRAMC and Fort Campbell, Kentucky. Counselor Advocates have facilitated a Heroes' welcome and community support for wounded service members reintegrating into communities in at least four states working with the DoD Heroes to Hometowns program and its American Legion partner.

I'd now like to focus on Traumatic Brain Injury. Not all injuries bleed, and mild to moderate brain injuries are considered the "walking wounded". While all injuries need special attention, the diagnosis and treatment of TBI is complex and requires creative solutions. Traumatic brain injury is unlike any other injury, illness, or disease. Everyone's brain is just a little different than the next person's brain. Therefore, two individuals with comparable insults to the brain can produce very different long term sequelae, or consequences. With advancements in battlefield medicine, ***severe brain injuries*** progress along the recovery continuum from treatment in theatre, to Landstuhl, and on home to the United States in a timely, seamless fashion. Once medically stable and able to participate in rehabilitative services, those wounded service members with severe brain injuries most often progress to one of the four VA Polytrauma centers. Acute, in-patient rehabilitative care for brain injuries at the Polytrauma centers is provided by a multi-disciplinary team. Social workers are able to connect the service members and families with the VA system and long term benefits since these wounded will not be able to return to active duty. When long term skilled care is necessary, the service member either returns home with family members who are able to care for them, or, if they do not have family or an appropriate support system, they are placed in a VA long term care facility in a which was not designed for this young population.

It should be noted that not all brain injuries sustained in theatre are severe, and other more obvious injuries often necessitate evacuation from theatre. These warriors receive in-patient treatment at a MTF where ***mild to moderate brain injury*** may not be identified or diagnosed. Once medically stable, the service member transitions to out-patient status assigned to a Medical Hold or Holdover unit. Initial symptoms may be minor or relatively non-existent, but may evolve over time and begin to be more apparent. Headache, memory and concentration difficulty, amnesia, sleep disturbance, reduced frustration tolerance and impulsivity, periods of confusion or mental dullness, mood swings, loss of self-confidence, fatigue and weakness, auditory and visual deficits, and slow reactions are common characteristics following mild to moderate head injury. Service members with this level of brain injury are compromised in their ability to navigate their environments and the systems needed to make forward progress along the recovery continuum. The service member is just not him/herself. Their ability to participate in traditional therapies for orthopedic and other injuries is also compromised. Diagnosis of brain injury is the first challenge. Usually, there are no abnormalities on routine neurological examination. Those closest to the service member with mild to moderate brain injury are often the first ones to notice that something is not right. There are many instances where families relate their concerns and frustrations have been discounted by social workers, case managers, physicians, Service branch representatives, and Command. Signs and symptoms of mild to moderate brain injury may be confused with those of post traumatic stress disorder. Until the Service Member has the correct diagnosis, treatment options may not be appropriate or even offered. Once a diagnosis has been made, the next step is to engage clinically appropriate care for the service member. Social skills are a critical indicator of success for any brain-injury survivor reintegrating into their lives and their community. Brain injury alters social skills – the ability to comprehend subtleties, to control emotions whether it is anger or sadness, or possess awareness of what is right and what may not be. These skills need to be worked on in real-life environments – home, places of employment, church, and recreational settings – all with the appropriate people. Only then can survivors of brain injury achieve quality of life. The consequence of

not recognizing mild to moderate brain injury, treating it, and supporting these Service Members and their families 100% during recovery is that families will encounter difficulty transitioning to quality of life. Families are at risk for domestic failure, failure in employment environments, and failure in social and emotional endeavors. Without treatment options and 100% support, many of these service men and women will end up in psychiatric units, homeless, or involved in criminal activity resulting in incarceration.

Challenges:

I think the challenge we face is the leadership, acquisition, and coordination of all of the resources needed to help the wounded. It's not that there aren't any existing resources--each service branch has a severely injured program. The Army has the Army Wounded Warrior Program, (AW2); the Marines, the Marine For Life Injured Support Program (M4L-IS); the Navy Safe Harbor Program; and the Air Force Palace HART Program. The VA established the Seamless Transition Program. DoD stood up the Military Severely Injured Center and the Heroes to Hometown program. The Department of Labor began the ReaLifelines Program and Operation Warfighter. Countless non-governmental organizations rallied with support of money, services, and goods. What ensued was discord. There is no clear cut or single definition of Severely Injured; the Army requires a wounded service member to have a 30% military rating (PEB) in a single category before they receive services from the program, and it is not unusual for the MEB/PEB process to take 18 months to 2 years to complete. The other Service programs are less stringent in their criteria. MOS/SI services strive to assist those within and on the fringes of the service definitions. I believe that not all wounded have received the same level of care coordination after returning from theatre. Communication between programs, NGOs, MTF resources, and VA systems is not robust, fully defined, easily understood or consistent. At present, the wounded and their families aren't getting the very best our country can give them.

If I may provide an analogy: an orchestra is a family of musical instruments each with its own distinctive sound and role. Total sound must be in harmony. The musicians are experts in playing their

instruments but it is the conductor who sets the tempo, executes clear preparations and beats, listens and shapes the sound of the ensemble from the initial note to the conclusion. Similarly, the recovery continuum begins at injury and stretches to attainment of quality of life (an accessible home, vocational opportunities, and meaningful relationships), and an effective recovery demands coordination. The process of meeting the needs of the wounded requires a conductor who orchestrates the personnel, resources, and services at the optimal moment to advance the wounded and their families toward reintegration and quality of life. I recall, for example, a Marine from Chicago who was involved in a blast injury resulting in visual impairment. The CA referred this Marine to the Defense and Veteran Brain Injury Center (DVBIC) where he was diagnosed with a TBI. Initially not recommended for outpatient rehabilitation, he began to have problems at work. The Counselor Advocate was able to recognize the need for a second evaluation which resulted in approval for outpatient treatment at a community rehab program. After completion of the MEB/PEB process, the Marine will return home to live with his parents where he will require additional support until he is able to live on his own. Connected by the CA, the family is also receiving funds from the Semper Fi Fund to finish their basement to accommodate their son. The CA is now addressing vocational options with VA Voc rehab and has secured adaptive equipment and software through CAP to enhance the Marine's quality of life. Without the orchestrated resources (MTF, DVBIC, Sharpe Rehab, VA, CAP, Semper Fi Fund, etc.), and the leadership of the conductor (CA), this Marine would still be struggling.

Recommendations: What I personally suggest is the following:

1. We need a single, central focal point for wounded and their families. A program that goes across the "colors" of the various service branches--a program to provide severely injured services that will transcend all service branches including Guard and Reserve units, 24 hours a day, 7 days a week. This program must have clear direction from senior level VA and DoD as well as Army, Marine, Navy and Air Force command endorsement. The program direction must include a system of coordination and

collaboration between the VA, DoD, MTF's ,individual service branch programs, NGOs, and DoL which will support a seamless and equitable delivery of service to all wounded men and women returning from war.

2. We need to expand options for care of the brain injured men and women returning from war. Existing in-patient care units are not meeting the needs of all traumatic brain injury cases. Out-patient clinics are too few, too far away, and not designed for this specialty population. We need to establish collaborative and cooperative relationships between private community based brain injury-rehabilitation programs, DoD and the VA that will allow service men and women with TBI to receive treatment as close to home as possible, in a setting that is conducive to attainment of skills, and with staff that have a specialty in brain injury rehabilitation. DoD has begun this collaboration with the Defense and Veterans Brain Injury Center. They have established a working relationship with Virginia Neuro Care and Lakeview Brain Injury Programs. We need to expand this collaborative approach to include more programs across the country. This network of providers can then complement existing acute rehabilitation services offered by DoD and the VA system, and expand to offer community re-entry programs.

3. Most importantly, these wounded warriors and their families need a qualified Advocate. The Advocate must possess the skill sets to help the families think straight, navigate through the systems, and transition successfully from the Department of Defense care to VA medical care and civilian communities.

Our wounded heroes have shown courage, determination and fortitude to protect our nation and its allies. Now it is our turn to show courage, determination and fortitude in marshalling our very best resources, systems and abilities to bring them home to a better quality of life.